State Pharmaceutical Assistance Transition Commission Meeting

Sponsored by the
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services

Held at the
Holiday Inn
415 New Jersey Avenue, NW, Washington, DC

Meeting Summary

Wednesday, July 7, 2004

(9:03 a.m.)

Participants

State Pharmaceutical Assistance Transition Commission present: Joan F. Henneberry (Chair), Clifford E. Barnes, Esq.; Donna A. Boswell, PhD, JD; James Chase; David L. Clark, RPh, MBA; Jay D. Currie, PharmD; Barbara Edwards; Nora Dowd Eisenhower, JD; Janice O. Faiks, JD; Dewey D. Garner, PhD; Karen Greenrose, RN; Laurie Hines, JD; Julie A. Naglieri; Dennis O'Dell; Robert P. Power, MBA, CBES; Susan C. Reinhard, RN, PhD; Sybil M. Richard, JD, MHA, RPh; Elizabeth J. Rohn-Nelson, consumer representative; Marc S. Ryan, MPA; Linda J. Schofield, BSN, MPH; Martin Schuh, MBA

Others present: Marge Watchorn; Kimberley Fox, MPA; Kathleen Mason; Jack Hoadley, PhD; Evelyn Gooden; Tom Morrison, RPh; Linda Flowers; Christin Englehardt; Stephen Crystal, PhD; about 50 interested persons

Welcome Attendees and Review Ground Rules

Ms. Henneberry, Chair, State Pharmaceutical Assistance Transition Commission, called the meeting to order at 9:05 and explained the how the meeting would proceed. After the U.S. Department of Health and Human Services Secretary, the Honorable Tommy G. Thompson, swears in commission members, official presentations will be given. Commission members will be invited to ask questions and then, if time permits, the audience may ask questions. At the end of the day, the audience can ask additional questions or give comments. Tomorrow (July 8) the commission will meet in closed session to begin its work and to prepare for the October meeting. Those who want to provide additional information after this meeting should contact Marge Watchorn, CMS.

Review SPATC Charter, Part D Benefit

Dr. Mark B. McClellan, M.D., Ph.D. welcomed members to this first meeting of the State Pharmaceutical Assistance Transition Commission (SPATC) and thanked them for agreeing to serve. Members were drawn from a broad array of backgrounds to deal with all questions the commission will have to deal with in order to implement the new law effectively. Secretary Thompson believes the new law is the most significant improvement in Medicare law since the law was enacted in 1965, especially for senior citizens and others of limited means. The Medicare drug card program enables seniors to group together to get prices that are 10 to 15% lower. Low-income beneficiaries will qualify for a $600 discount and wrap-around benefits, which will be fully implemented by January 1, 2006. CMS is working on other programs for the 2006 implementation—e.g., alternatives to drugs Medicare now provides—with the intent of providing real relief for beneficiaries in coordination with the states.

Analysis of the new law, which was passed in 2003, indicates that comprehensive benefits for seniors and low-income people in addition to employer benefits will also benefit the states because it helps states defray costs. Nevertheless, states will face some new costs (e.g., "claw-back" provisions, and additional beneficiaries, as more people may sign up for benefits and services). Commission members are needed to ensure that the law will be implemented as intended, without interruption of benefits and care. And, the program must be running effectively within the next year and a half. In the course of addressing these issues, members should ask themselves, how the enrollment process can be simplified, what processes state programs need in order to evolve, and what will help the agency and Congress to make the transition happen as smoothly as possible. For Part D, health care providers and policy makers can build on the experience gained from implementing the prescription drug card program.

Q&A

- The time table is "as quickly as possible"—the sooner CMS gets input, the better. CMS is working on proposed regulations now. In addition to the regulations themselves, process issues within the regulatory structure must be worked out. The overriding concern is that the drug benefit be delivered by January 1, 2006, which includes having education and outreach programs in place before then. CMS will work closely with this commission, so the commission's discussions will be influential to the process. CMS is not anticipating additional legislation, which would slow the process.
- Getting the drug card program in place has required CMS to work closely with other groups that already work on issues for low-income people, and may have plans in place, such as, the Social Security Administration and interagency groups. CMS wants to know if they should be aware of additional groups.

Swearing in the Commission Members

After greeting each commission member, the Honorable Tommy G. Thompson expressed his appreciation for members' willingness to take on the responsibility of getting a report out by January 1. Seniors are already saving money with the Medicare Modernization Act, passed last year, especially low-income seniors. This commission will help ensure that low-income beneficiaries who currently receive drugs through the state will continue to get drug benefits without additional paperwork. The commission should examine different ways the states can develop a single point of contact, and how states can wrap-around new benefits. The report will be submitted to the President and Congress by January 1, 2005. Secretary Thompson

announced that the U.S. DHHS will release $125 million in grants, distributed to state assistance programs over the next 2 years. The grants will help ensure that low-income beneficiaries understand the new Medicare law and get the best possible benefits under it.

Commission members rose and Secretary Thompson swore them in as a group. A group photo was taken with the Secretary.

Formal Introductions—SPATC members

Commission members introduced themselves when they commented or asked questions. Public members were asked to sign in.

Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs: Key Issues and Concerns

For the past 3 years, Ms. Kimberley Fox, Senior Policy Analyst at Rutgers Center for State Health Policy, has been conducting a study comparing and contrasting state pharmacy assistance programs (SPAP) and comparing SPAP benefits with Medicare benefits. Several reports have already been issued and 2 more will be released soon. Ms. Fox distributed copies of her presentation and noted that it and her other reports are available on their Web site.

In 2003, 22 states had SPAPs, but design varied considerably. With average income eligibility limits of 220% FPL, the principal challenge for SPAPs will be addressing prescription drug affordability for the near-poor and those with some assets. (These people are eligible only for the basic Part D benefit, which is typically less generous than SPAP benefits.) Enrollment challenges will be significant, beginning with estimating low-income eligibility. Determining eligibility through Medicaid rolls may discourage people from enrolling because of the stigma associated with receiving Medicaid. Furthermore, many beneficiaries will not meet the Medicare asset test, and gathering asset information will be difficult for programs that had not previously required that information. Medicare drug formularies and pharmacy networks are likely to be more limited than SPAPs formularies. Most SPAPs plan to continue some low-income drug coverage in 2006, but are focusing on implementing discount cards and are still considering Part D coordination of benefits options. Missouri leads in proposing to supplement during the “donut hole” period.

The experience with discount cards is likely to be repeated with implementation of Part D, so it is important to learn from the discount card experience. States have an interest in getting people enrolled, but most states have not yet required enrollment, although they have facilitated it. Most eligible beneficiaries will be automatically enrolled. Coordinating payment from other third-party payers where the state is deemed the payer of last resort may require additional state audits and oversight to ensure compliance and to prevent double billing. In addition, it is not easy to get information from private insurers, so, many states employ information brokers, an extra expense. Other challenges include what to do with non-network pharmacies and whether to wrap-around coverage.

Whatever form the SPAP programs take, coordinating their benefits with Part D will not be easy. It will require a significant amount of information exchange that is unlikely to go

smoothly, and the more plans, the more difficult coordination will be. To minimize the burden of coordination, centralization of information-sharing, perhaps at CMS, is key. Auto-enrollment is the most efficient way to get people enrolled in Part D plans. Challenges will include: dealing with denials and resubmitting appeals, tracking disenrollment, and monitoring spend-down.

Q&A

- *Linda Schofield, Jay Currie, Marc Ryan, Barbara Edwards, Susan Reinhard:* Nonmandatory *auto-enrollment* means states offer beneficiaries an "opt-out" if they don't want to use the discount card, but initial opt-outs have been found to result from confusion. Table 4 of the presentation shows that some states are wrapping-around benefits of discount cards, even if the beneficiary is not using the preferred card. To opt-in, the beneficiary has to show the card only once, and the pharmacy keeps the information on record. This requires educating the beneficiaries. States with voluntary sign-up don't know how they're doing because they haven't received the CMS report, so they can't know whether there are any trends. States have found grassroots meetings to be an effective education mode of informing beneficiaries. Auto-enrollment of people eligible for other programs is also effective; a report on this will be available. Connecticut is auto-enrolling people, and allows them to select whatever drug card they want. Of an estimated 25,000 eligible for transitional assistance, about 18,000 have been enrolled so far. Of those, 13,000 chose to enroll, so the state has had to enroll only about 5,000 people for whom card selection was random. Auto-enrollment is really repetition—they're enrolled because they were already determined eligible because the were enrolled in another program. Auto-enrollment is also sometimes a timing issue, e.g., it requires the state to be the authorized representative of the beneficiary. Some states don't work with a preferred drug provider, so they had to issue an RFP to identify one, which can be time consuming. Auto-enrollment for Part D is still moot and the drug card model could be modified for Part D. The drug card piggybacks off the Medicaid discount. It would be helpful to know the results from states that have auto-enrolled.
- *Nora Dowd Eisenhower, Susan Reinhard:* In Connecticut, they hope to *expand eligibility*, as Indiana did, but this is a legislative issue. The $600 discount can be used for formulary and non-formulary drugs. People in transition often pay a lower co-pay; many times, they pay only 50 cents or a dollar until they incur $600.
- *James Chase, Julie Naglieri, James Chase: Formularies* are a way to control the costs, but there may need to be some transition between open and closed formularies. Open formularies have resulted from rebate offers rather than policy. States are concerned about unintended consequences of drug plans. In New York, one plan was convenient and they enrolled many people. With the drug card, there are no formulary issues, which there will be with Part D, and the states will need flexibility. We need to keep in mind the medical side—the charge mentions the MMA. States should have flexibility to integrate plans.
- *Susan Reinhard, Linda Schofield, Nora Dowd Eisenhower, Marc Ryan:* To the degree that states wrap-around coverage, switching from a *preferred drug plan* to the drug card could pose a problem for states in the amount of money they receive. CMS is now working with a preferred drug plan as a potential lead-in to Part D. The logistical hurdle overcome by drug card enrollment could be overcome by preferred drug plans. States would probably follow an RFP procedure to select a preferred drug plan. This is an important question for SPAP states, especially in full drug plan roll-out. Auto-enrollment in a preferred drug program may affect MA/PDP requirements, e.g., auto-enrollment into

a plan that doesn't have the beneficiary's drug or plan. Part D allows plans to change formulary only annually, so beneficiaries could be locked in for a year to a plan that doesn't meet their needs. People don't read their mail, and some states have more managed care than others, so a good education effort will be necessary to be sure people understand their choices. CMS should also allow states to not restrict beneficiaries to one or two plans. However, the administrative burden of integrating with a number of providers would be much more difficult.

- *Martin Schuh, Marc Ryan, Linda Schofield:* The bigger plans totally *wrap-around,* so the SPAP beneficiary's role will not change, and which plan they get will be irrelevant to the beneficiary. It's much more relevant to the state. However, many states have much more limited plans, and which card is chosen will make a difference. We need to reduce the burden for the pharmacist. Many states step in to pay part of the claim, and, if someone goes to the pharmacy without a discount card, they don't get the discount.
- *Robert Power, Donna Boswell: Private health plans* will have to be considered. (AB plans cover Parts A and B of Medicare; ABD plans cover Parts A, B and D of Medicare.) In coordinating benefits with *third-party payment*, the state will still be the primary payer; Part D reverses this: when a third-party payer is involved, the state is the payer of last resort.
- *Donna Boswell, Marc Ryan:* There is an *anti-discrimination provision* in the statute that allows *flexibility* when coordinating with Part D. You can't discriminate but can pay a lump sum (which implies that you can work with a lump sum); also there's one emblem. States prefer one plan but permit all plans. States need CMS guidance on antidiscrimination language.
- *Robert Power:* The *data file-match* centralized at CMS hasn't many fields yet, but it will provide useful tracking information, and will be useful for Part D, as well.

Coordinating Benefits: What Changes in Medicare Mean for New Jersey's State Pharmaceutical Assistance Programs

Ms. Kathleen Mason, New Jersey Department of Health and Senior Services, New Jersey Prescription Assistance to the Aged and Disabled /Senior Gold, Trenton, described New Jersey's experience with the new prescription drug card. New Jersey's Prescription Assistance to the Aged and Disabled (PAAD) is the oldest such plan in the country, established in 1975; Senior Gold was established in 2001. PAAD has 191,000 enrollees; Senior Gold, 29,000. For those on PAAD who are not eligible for transitional assistance, it's not worthwhile to apply for a discount card. New Jersey has about 81,000 PAAD beneficiaries who are eligible for transitional assistance. First, PAAD sent letters to every beneficiary telling them to do nothing. Then it sent a second letter to those who would benefit from enrolling in the discount card program, offering eligible beneficiaries an opt-out of auto-enrollment. Meanwhile, PAAD issued an RFP to the 21 Medicare discount purchasers in New Jersey, received 6 proposals for a preferred prescription discount card, and awarded the contract to Medco. Beneficiaries got a letter saying they would be auto-enrolled unless they opted out. Lessons learned from this auto-enrollment experience include: A welcome kit is required, but including a price list, etc. confused beneficiaries. Standard benefit information provided by drug card sponsors will confuse beneficiaries and may contradict what SPAPs provide. People who were not auto-enrolled (those in the long-term care, those who had other

insurance, and those in Medicare + choice plans) are not losing anything. Transitional assistance is a benefit in addition to a person's regular PAAD benefits.

When a claim is made, the pharmacist submits it to Medco first and then bills PAAD for costs not covered (less the $5 co-pay). If the beneficiary comes to the pharmacist without a card, the pharmacist can call the PAAD hotline, where operators have eligibility information on-line and can give information over the phone.

Problems encountered included some 6800 error records. Of these, 1100 were Medicaid disenrollments when matched against Medicaid records; 150 were on Managed Care Exclusive Cards (a non-New Jersey card)—they rely on CMS information for this, and the CMS file-match system is not yet ready; and 60 live in Puerto Rico and are not New Jersey residents (Social Security is the final determination of state of residence). A group of people will always fall between SPAP and Medicaid because people may be Medicaid eligible one month and not the next. This experience underscores the need for current files that provide timely and accurate information. The difference between auto-enrollment and auto-application is that there are additional checks and balances after initial application.

From this initial experience, PAAD learned that when a letter says the beneficiary has to do nothing, some take it literally and don't renew their PAAD application. Many beneficiaries don't pick up their own medication, so PAAD sent out a press release saying the card was in the mail and the beneficiary would need it to pick up prescriptions. However, hot-line operators can walk the pharmacist through the system if the person has no card.

Concerns for 2006:

- Who will determine eligibility for Medicare Part D for PAAD beneficiaries? SPAPs are a logical choice.
- How will assets be defined? The asset test complicates eligibility, and the cash surrender value of beneficiaries' life insurance policies introduces a new problem.
- Too many PDP options will mean that many people will not choose any plan.
- Will enrollment be mandatory? If so, it will require legislation in states like New Jersey to change the existing programs.
- Coordination of benefits with several different plans with different pharmacy networks and formularies will complicate the issue; it would be difficult to enroll without auto-enrollment.
- Files matches with several different plans could be a source of problems. We need a process to match files and automatically bill the state.
- Will the state cover a drug that is not in the plan's formulary or a pharmacy that is not in the plan's network? In New Jersey, it will be difficult not to because beneficiaries are used to having all drugs covered.
- How does a state pay premiums for beneficiaries? Does it pay CMS or each PDP? Complications arise for the partial subsidy population whose income is between 135 and 150% of the federal poverty level (FPL). Using buy-in for Part B for Part D could work. Theoretically every beneficiary in the sliding-scale group could pay a different premium. New Jersey beneficiaries whose income exceeds 150% FPL would pay the full premium amount.

Despite all, the system is working in New Jersey: 68,000 people have been enrolled and have cards, and the state expects to save $90 million in FY 2005 ($1200 per person).

Q&A

- *James Chase, Robert Power, Linda Schofield:* There should be multiple ways beneficiaries get into the system. New Jersey's first claim was filed a week after the opt-out date, but there was no problem with the *volume of claims* because pharmacists are accustomed to processing claims. New Jersey agrees to pay pharmacies as much as the PAAD assistance rate, which is higher than most of the discount cards' rate. However, because most of the New Jersey population exceeds the 150% FPL, most people in New Jersey are not eligible, and the state could handle the remaining eligible ones. Generally states find that discounts aren't worth much other than the $600 deduction, but New Jersey asked discount card companies what their discount rate was. Medco's was less generous, but Medco includes almost every pharmacy in New Jersey. New Jersey supplements the card up to the PAAD rate.
- *Marc Ryan:* If state plans are more flexible in determining *eligibility*, it may be another major issue to look at. The Connecticut system differs from Medicaid. In New Jersey, eligibility is based on current anticipated income, which is matched with IRS records from prior years. And, CMS gives override ability, e.g., in instances of recent retirement and other dramatic reduction in income. CMS has not decided whether this will become policy in 2006.
- *James Chase, Marc Ryan, Donna Boswell:* The card may not save money for the full payment, but *rebates* change things. How to collect rebates on drugs for which you receive partial payment is a complicated issue that varies by state. (New Jersey legislation requiring rebates expired years ago.) Medco is passing any rebate at point-of-sale to the beneficiary; since when New Jersey picks up the remainder, it balances out—the rebate is passed through as an increase in savings. A free drug program is really a rebate from the manufacturer. Connecticut discounted the $600 because the rebate they were already getting would exceed what they got on the cards. In New Jersey, it exceeds $600 because the cost coming through on the claims includes the amount the pharmacy charges. New Jersey pays 10% of the cost of a claim, not the full cost of a drug. Medco can tell you which drugs they collected a rebate on.

Public Presentation

Dr. Jack Hoadley, Research Professor, Health Policy Institute, Georgetown University, Washington, DC, is conducting case studies of 14 states that have had active pharmaceutical assistance programs for seniors for at least 2 years and have at least 5000 enrollees. They are gathering information on operational concerns such as coordination of benefits, communicating with enrollees, administering eligibility and cost sharing, approaches to managing drug costs, and how states are considering modifying their programs in response to the new Medicare discount card and Part D drug benefit. Discount cards may offer something people don't get with the state program.

Some states have had no experience in coordinating benefits, and experiences will repeat themselves under Part D. On the administrative side and for the pharmacy states need to comply to prevent added burdens for the beneficiary. Preliminary observations include:

- State programs and CMS are beginning to gain some beneficial experience in working together, so the line of communication has been well established.
- Part D benefits will affect all state enrollees and all state programs, but many questions remain—e.g., auto-enrollment—that will be driven by what kinds and how many plans participate in Part D. Plan providers have a year to commit.
- Some states have experience with coordinating benefits; for others it's all new. From a beneficiary's perspective, many have seamless coverage and don't want to change.
- Under Part D, coverage will come from 2 sources. In some states gaps in coverage will result (e.g., covering only certain classes of drugs).
- States have an opportunity to expand coverage by wrapping around existing benefits so beneficiaries will have coverage in the future that is at least as good as what they have today. There may be a chance to add classes of drugs or beneficiaries (e.g., disabled persons), but, this implies political obstacles.
- Last is the communications challenge: The drug discount card presented few changes—you don't need the card, you will get the same coverage, and most people don't qualify anyway. Part D will include nearly everyone: low-income people and upper-income people. Therefore, the message will be much more difficult to convey and will have to be paid for, but most states don't have a budget for communication. Partnerships with programs such as SHIP may be challenging.

Most case studies are in progress or haven't started, but the Health Policy Institute is happy to incorporate into their studies issues the commission raises.

Public Presentation

Ms. Evelyn Gooden, President, Illinois State AARP, presented AARP's testimony. AARP has played an active role in promoting SPAPs because they help fill the gaps in the new drug benefits program. The MMA legislation specifies that there be a single point of contact between enrollment and dispensing of benefits. To comply with this, responsibilities should be clearly defined so there is no disruption in benefits. Coordination should include ensuring that SPAP enrollees get the best price available. Additional issues to be addressed include:

- SPAP eligibility is based solely on income criteria, so SPAPs generally provide benefits equitably, but the new legislation requires an asset test that unfairly penalizes low-income people who have saved money for retirement. AARP will be working to eliminate this asset test.
- There should be no distinction between waiver-based and other SPAPs' spending toward individual enrollees' out-of-pocket threshold for the catastrophic coverage cap. Such distinctions are unfairly burdensome to beneficiaries and payers.
- SPAPs vary widely. Requirements for coordination between SPAPs and Medicare drug plans must provide for this variation and not restrict SPAPs in ways that might reduce or eliminate coverage.

Many SPAPs were enacted as a bridge to a full Medicare drug benefit, but the new Medicare program is only a beginning and much needs to be done before it becomes the comprehensive program beneficiaries need and deserve.

Rx Transition Issues for Medicare Beneficiaries

Tom Morrison, Vice President, Pharmacy Services, CVS Pharmacy, Woonsocket, RI, also represents NACDS, a trade association for chain pharmacy companies (217 chains that operate 32,000 community retail pharmacies), which dispense 70% of all outpatient prescriptions. From the patient's and the pharmacist's point of view, the commission will have succeeded if it creates an efficient process.

Chain retail pharmacies are the primary source of prescription drugs and are therefore the primary point of service and primary source of information for enrollees. Transition issues include:

- Education for both beneficiaries and pharmacies: Frequently pharmacists learn about plan changes only when a patient wants to fill a prescription. Getting readable information is critical. Oftentimes beneficiaries try to use the pharmacist to get information about their plan. Could the process be standardized?
- Operation of formularies and pharmacy networks: Some beneficiaries have been taking certain drugs for many years, but their drug may not be on the formulary or they may have to pay a higher co-pay. How does the pharmacist handle this? Thousands of drug switches will be possible January 1, 2006. Furthermore, the January date coincides with the date many private plans change. If the patient's pharmacy is not in the network, it increases the potential disruption in continuity of care. Maybe these implementation of the new law could be gradual.
- Electronic, on-line, real-time claims processing at the point of service: The commission should thoroughly rethink any process that may fall back to manual processing. For dual coverage, pharmacies must have key question answered in real time. Most prescriptions are now processed electronically on-line in real time.
- Coordination of benefits among payers: The insurance industry is accustomed to managing coordination of benefits; at the same time, providers have trouble managing this function because not all pharmacies participate in all plans. Billing sequence information—who's the primary, who's the secondary—should be on the drug card, i.e. the next payer of benefits when drugs are not covered, plan limit has been exceeded, or formulary exceptions have been made.
- Access to insurance information databases on beneficiaries would facilitate coordination of benefits. Can an umbrella entity capture information at enrollment and coordinate this activity behind the scenes? If not, there's the question of paying for coordination of benefits information. Neither patients nor pharmacy providers should be responsible because of the duplicate work and increased system, processing, and training costs.
- Use of the NCPDP standard benefit card is important. The card should indicate whether the person has other coverage; should allow the pharmacist to access electronically all information needed to bill; and should be in use when benefits start.

Retail pharmacy is where the "rubber meets the road" in providing drug benefits. Most claims are successfully processed in real time in seconds, and obtaining information in real time is key to driving the system forward.

Q&A

- *James Chase, Marc Ryan, Sybil Richard, Robert Power:* Key to a coordination of benefits system is that we not reinvent the wheel. Some states have had systems in place for years—whether for car insurance or health insurance—that can exchange *information* between carriers, and we should take advantage of that experience. All have a part in the process and all want to see that the system works efficiently and smoothly. It must be possible to capture information during enrollment as to whether the beneficiary has multiple coverage, and it is necessary to maintain contact over time to capture changes. But, real-time on-line processing, and payment are 2 difficult issues. Financial issues as well as administrative issues must be addressed. A state that requires pharmacies to accept all cards is unduly burdensome, and in fact CVS turns down prescription drug cards that incur added administrative problems. Most plans use NCDCP to coordinate. Pharmacies introduced electronic claims processing in 1990, but it still doesn't address many issues. Any group could be the coordinator, but the issues most often encountered relate to Medicare and Medicaid, which CMS could easily deal with.
- *Dewey Garner, Jay Currie:* NCDCP standardized what a *health-care card* should look like because they had encountered so much variability. The card they ended up with may offer a starting point. Every time things change, the card may have to be reissued, which is expensive, so a related question is how to avoid reissuing cards. But, at some point in the future we won't need the card. Is a standard being looked at to get enrollment information back to the pharmacies? Some problems seem to come from trying to build a prescription based on information at hand, which is incomplete or wrong.
- *Martin Schuh, Linda Schofield:* A good (clean) *claim* is one where the pharmacy can extract all the information necessary to produce the correct medication at one time—being able to pass on the information and get paid. Interruptions in that process—reject information such as, pharmacy or physician is not covered; patient is not on file, etc., etc.—mean you have to identify what component is wrong, e.g., date of birth is wrong in the database, and get it fixed. When a claim is rejected, the reason is not always clear. NCDCP and CVS have taken it upon themselves to meet with primary payers to get reject information and have gotten them to refine that information, so the pharmacist can resolve the problem. Often it's an input error.
- *Robert Power, Linda Schofield: Coordination of benefits* just adds to the complexity. As a company, CVS is just beginning to use this program and has found that, when it comes to coordination of benefits, they can't distinguish between 2 health plans. The commission may want to look at a standard the pharmacies should be provided with, so they will know when to bill the state.
- *Linda Schofield, Barbara Edwards: Co-pay* information is usually passed back by an intermediary or the payer. But there are multiple tiers for co-pays, which has implications for the education component. In addition, more than half of patients use a Web site to refill prescriptions, and many patients don't know whether they have other coverage, so pharmacists rely on an intermediary for this information. Trying to keep the plan simple and consistent will be a challenge for the commission.
- *Dennis O'Dell, Martin Schuh, David Clark:* The ideal situation for pharmacies would be getting the information they need at one time. Second best would be real-time corrections. Realistic *standards and expectations for pharmacies* may be a goal for this commission. If administrative hassles are too burdensome, pharmacies will opt out. Perhaps PDPs and MAPDs could address this. However, even with old 442, not all pharmacies did anything

with the information they received, so expectations shouldn't be too high. What can the commission do to streamline the process for the pharmacist?

- *Barbara Edward, Marc Ryan:* Experience has shown that when the state is the second payer, there is no incentive to provide information about other coverage. We should not assume that all parties come with equal incentive to *share information*. Moreover, *HIPPA* will require that pharmacies capture only the information necessary to fill a prescription and that they safeguard that information. Yet, we need a process that makes it possible for payment to occur.

Open Session for Public Comments

LINDA FLOWERS, PUBLIC POLICY INSTITUTE, AARP

Ms. Flowers would like recommendations on denials. One way a claim can be denied is when the claimant cannot pay the co-payment at the point of service. With a 2-step process, the beneficiary may get caught in the middle. Coordination of benefits should be thought through, and if there is a problem, e.g., incorrect date of birth, are we looking at temporary dispensing (a Medicaid type of rule) or some other process that will protect the beneficiary? What kinds of legal protections have people lost by moving into this environment? A host of rules in Medicaid protect the consumer and some of those rules may be adaptable to the new system.

CHRISTIN ENGLEHARDT, HEALTH ASSISTANCE PARTNERSHIP

Ms. Engleheart reiterated the importance of the role the State Health Insurance Programs (SHIP) can play in education, making presentations at senior centers, religious organizations, and elsewhere. It makes sense for SHIPs to play a larger role, and CMS should take advantage of the volunteers who are already in place. The programs are funded through the federal government but some states give supplemental funding.

STEVE CRYSTAL, PH.D. RUTGERS CENTER FOR STATE HEALTH POLICY, NEW BRUNSWICK, NJ

The drug card program entails education and outreach. On the whole, Rutgers Center for State Health Policy has found uptake for state program to be quite good because people have become familiar with these programs over time. When there are major changes, consumer education needs to increase proportionately—communication is no longer a minor issue. That ties in with benefits. CMS assumes an informed consumer who is able and ready to make complicated choices, but that ability varies greatly, and hopefully this commission will provide some corrective perspective on this issue. Medicare savings programs are clearly involved. Many likely consumers of this program have some level of dementia or limitations that preclude them from making many of these decisions for themselves. The consumer choice mantra must take into account some of these situations; otherwise many people will not be served.

Quality management is another issue. We should not lose sight of the role the state has played, and we need to design these systems in a way that makes that possible. E.g., if claims are split between 2 systems, neither of which has all the information, it becomes nearly impossible to do the necessary follow-up. The data must still available to people who need it. (New Jersey and Pennsylvania have taken leadership in this area.) Incredibly important from

a public health point of view is that the massive amount of data that will be generated not become privatized and unusable. An issue that hasn't come out yet is that there should be room for commenting as to how states spend their supplementary money. Must all the cards be treated the same? If a card company wanted to wrap-around benefits with the state's benefits, it should entail stringent requirements to share data with the state. States should not become mere handmaidens.

Q&A

- *James Chase:* Since Medicare began, the Medicare and Medicaid database has been made available to researchers. But unless incentives are present and the expectations are clearly stated, those expectations don't happen. These data should not be allowed to disappear for researchers at the very time researchers are starting to realize that they need to understand these things based on the total population. But, recently availability for researchers of the Medicare and Medicaid database has become a matter of debate.

Closing Remarks

Ms. Henneberry closed the public session and invited commission members to remain for a 1- or 2-hour closed session to begin breaking into subcommittees. They will work diligently over the summer so that their work will essentially be done by the mid-October meeting. That meeting will probably involve 1 day of closed sessions, and 1 open. The commission welcomes comments and input. (To contribute, contact Ms. Marge Watchorn, CMS.)

Meetings "open session" was adjourned at 3:20 pm. Committee members continued meeting in closed session.